Arizona Department of Health Services
Office for Children with Special Health Care Needs
Integrated Services Grant

Family Profile

Your Name (first and last):

Address (P.O. Box, number, street, apt. #):

City: State: Zip Code:

County:

Telephone: Fax: Cell:

E-mail address:

Language(s) spoken:

Information about your child(ren)/youth or adult:

1. Age: Special need or disability:
2. Age: Special need or disability:
3. Age: Special need or disability:
4. Age: Special need or disability:

Services and/or supports your son or daughter is receiving or has received in your community:

Education:

§ Early Intervention Yes _____ No _____
§ Head Start Yes _____ No _____
§ Special Education Yes _____ No _____
§ Vocational Rehab Yes _____ No _____

Health:

§ Private Insurance (example, Blue Cross, Aetna) Yes _____ No _____
§ Public (example, AHCCCS, AHCCCS/LTC) Yes _____ No _____
§ Children's Rehabilitative Services
§ Behavioral Health Services Yes _____ No _____

Legal:

§ Child Protective Services Yes _____ No _____
§ Juvenile Court Yes _____ No _____

Division of Developmental Disabilities Yes _____ No _____

Others services/supports you want to mention:_____

_____

_____

Do we have permission to add your name and address to the mailing list? Yes No

Do we have permission to share your contact information with others:

Task Force Yes No

Other Committees Yes No

Do you grant us permission to take and use your photograph for the website and printed materials (e.g., office newsletter, brochures, etc.)? Yes No

What are your individual interests and passions about improving the lives of families and children with special needs?

How have you been a leader?

Have you had any leadership training or classes?